Understanding Montana Workers' Compensation (WC) Facility Fee Schedule UNIT TWO: USING THE UB-04

New updates of information, similar to FAQ, will be added to this educational module on a regular basis, so please check the date at the bottom of this page regularly to keep up with additional fee schedule information.

A Power Point educational module created by the Montana Department of Labor (DLI) in March, 2009. Actual regulations in the <u>Administrative Rules of Montana</u>, of course, take precedence in case of any misstatements in this educational module.

March 19, 2009

Unit Two: Using The UB-04: Billing Forms for the Montana MS-DRG (inpatient) and APC (outpatient) Facility Fee Schedule

For use with the Montana Facility Fee Schedule for Workers' Compensation (WC) Reimbursement

What You Need To Do First

This educational module is designed based on the assumption that you have already learned the materials in <u>Unit One: Essential Information</u>

<u>about the Montana Facility Fee Schedules for Workers' Compensation Insurance.</u>

<u>Unit One</u> is located on this same state web page, so you should be able to find it easily and master its contents before beginning this second unit.

Educational Module Organization

- Section One: Locating required Information on the UB-04 Form
- Section Two: Examples of Processing Inpatient (MS-DRG) Bills
- Section Three: Examples of Processing Outpatient (APC) Bills
- Section Four: Other Ways of Paying
- Section Five: Other Resources

Get Ready to Process UB-04s

- <u>Unit One</u> introduced you to the Grouper/Pricer concept for determining MS-DRGs and APCs, and gave a few examples of the billing process for the Montana WC reimbursement system.
- This <u>Unit Two</u> provides multiple examples of how to process the bill for payment. If, after working through all these examples, you still cannot complete a particular bill, please send us an email at www.wwilkison@mt.gov and we will attempt to help you. Meanwhile, for correlation purposes over the next few slides discussing portions of the UB-04 form, the very next slide is an image of the UB-04 form as a whole.

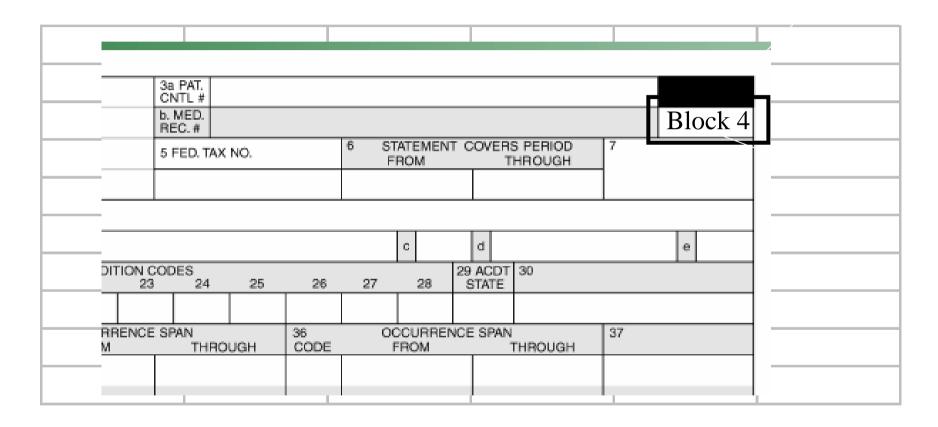
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What does the UB-04 form tell me? Is It An Inpatient or Outpatient Bill?

Remember that a bill from a hospital facility can be for either inpatient or outpatient services, so be sure to confirm that the code entered into Block 4 on the upper right corner of the UB-04 form is either

- 0111 (inpatient services, for which you use a MS-DRG Grouper) or
- 0131 (outpatient services, for which you use the APC codes and process, as described later in this learning module)
- There are quite a few other codes that can be entered in Block 4, but most may be payable at one of the 75 percent reimbursement rates described in Section Four of this learning module

Right Upper Corner of UB-04, Block 4

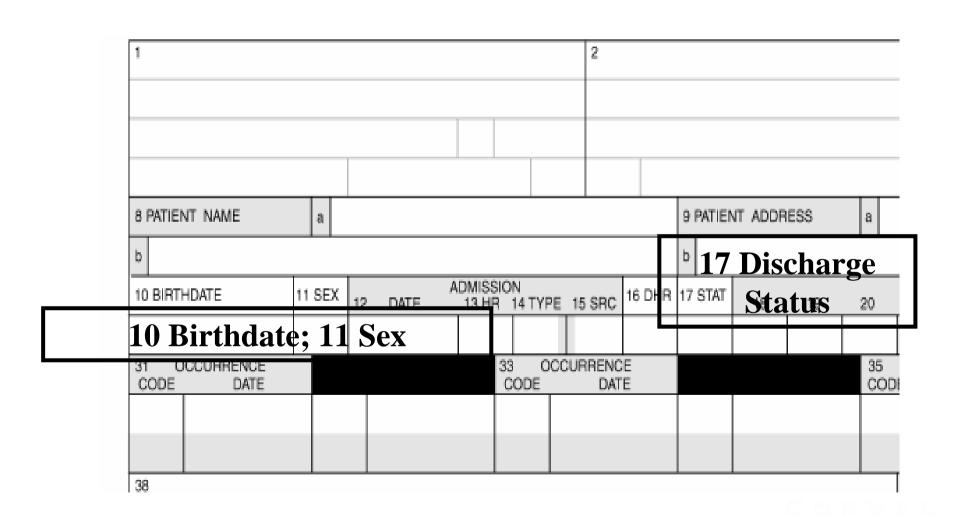


Does Block 4 include 111, 131, or another code?

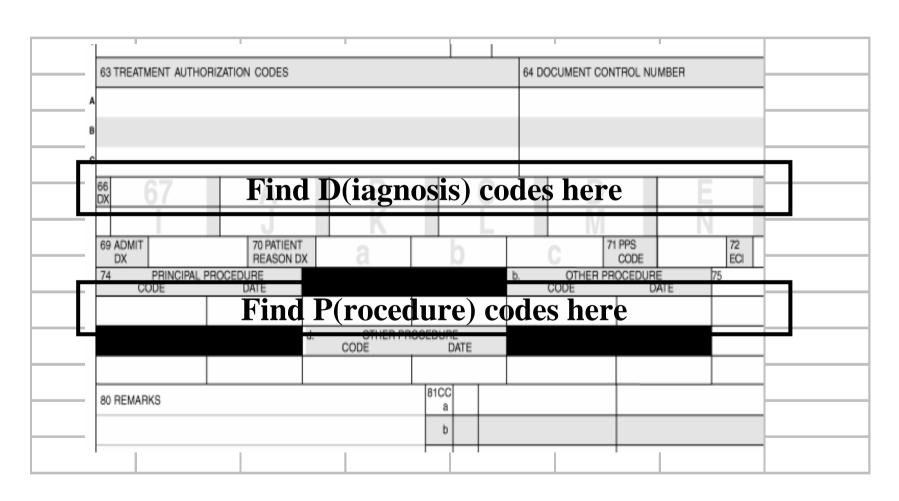
Where do we find the required claimant information?

- Patient information (age, sex, discharge status) is in the upper left corner
- Medical information (Diagnosis & Procedures) is in the lower left corner

Required Patient Status Information is in the upper left portion of the UB-04



D & P Codes are Located in the Lower Left Corner of the UB-04



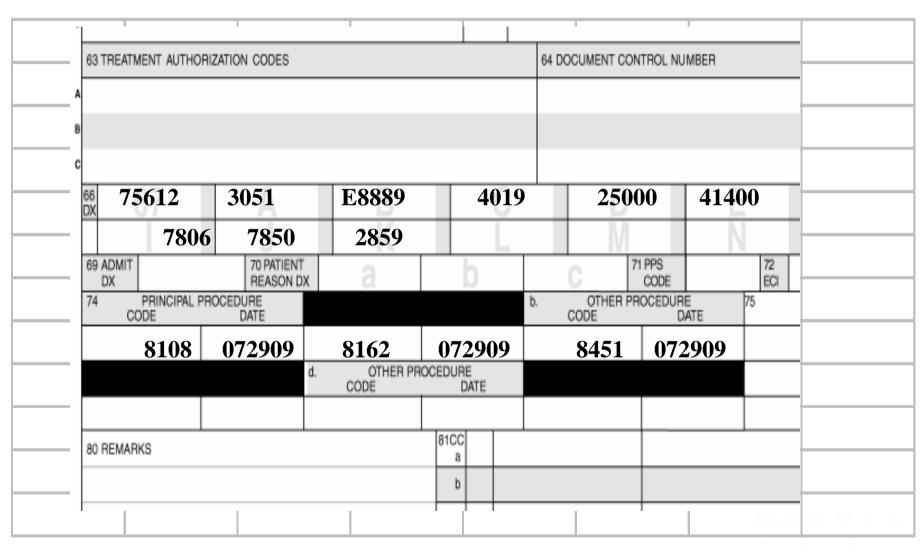
From the UB-04 to the Grouper

- Now that we know where to find the required UB-04 data to enter into a Grouper, let's go over the use of the MS-DRG Grouper
- First, open up the free Grouper at <u>www.hospitalbenchmarks.com</u> so that we can generate a corresponding Medicare Severity- Diagnosis Related Group (MS-DRG) classification code

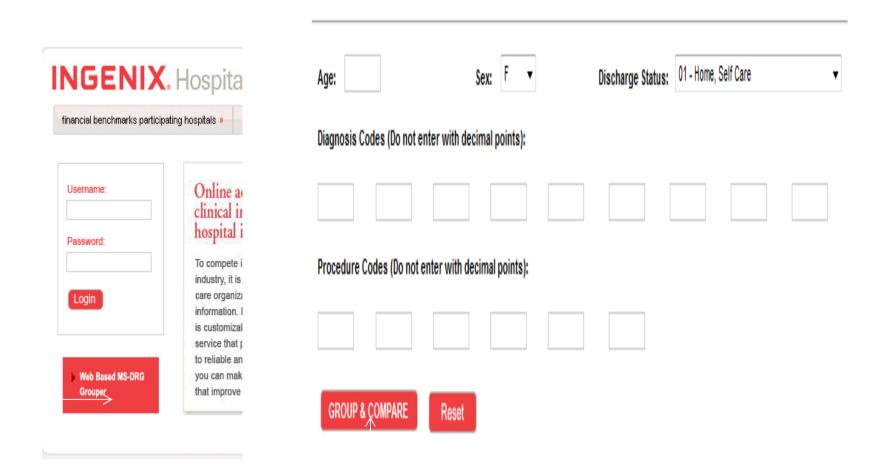
Summary from Unit One On the Use of the Grouper

- Using an MS-DRG Grouper with a UB-04 (see the sample UB-04 and Grouper form on the next three slides):
- 1) Enter Patient information from the UB-04 onto the first page of the Grouper
- 2) Identify the Diagnosis (D) and Procedure (P) Codes on the UB-04, & proceed only if Block 4 includes code 0111 (which equates to inpatient services)
- Insert the D & P Codes in the order, left to right, as they appear on the UB-04, into the correct cells on the Grouper. As you enter the D & P codes, remember to not include the decimal. Once you have all codes inputted, press the "Group & Compare" button. Remember also that the number of cells (or blocks) available on the Grouper for input represent the maximum number of D&P codes that create the MS-DRG code.
- 4) Confirm the reimbursement amount cited by the Grouper-generated MS-DRG code with the Montana Facility Fee Schedule section listing that MS-DRG code. Note also that Montana uses a rounding whole dollar reimbursement calculation for the MS-DRG reimbursement.

Example #1: Enter the medical data (D & P) from the lower left-hand corner of the UB-04 into the Grouper



Example #1 in the Grouper (page 1 of 2)



Example #1 in the Grouper (page 2 of 2)

Diagnosis C	Diagnosis Codes (Do not enter with decimal points):									
75612	3051	e8889	4019	25000	41400	7806	7850	2859		
Procedure (Codes (Do not	enter with dec	cimal points):							
8108	8162	8451								
GROUP 8	COMPARE	Reset								

Grouping Results:

CMS v24 DRG Assignment:	498 (SPINAL FUSION EXCEPT CERVICAL W/O CC)	[Pre MS-DRG year
CMS v25 (MS) DRG Assignment:	460 (SPIN FUS EXC CERV WO MCC)	Last year MS-DRG
CMS v26 (MS FY2009) DRG Assignment:	460 (SPIN FUS EXC CERV WO MCC)	Current year MS-DRG]
MDC:	08 (Diseases & Disorders Of The Musculoskeletal Sy	stem & Conn Tissue)
CMS v24 DRG Weight:	2.9896	
CMS v25 (MS) DRG Weight:	3.4870	
CMS v26 (MS FY2009) DRG Weight:	3.5607	
CC Diagnosis:	None	
MCC Diagnosis:	None	
*	Updated to CMS final rule.	

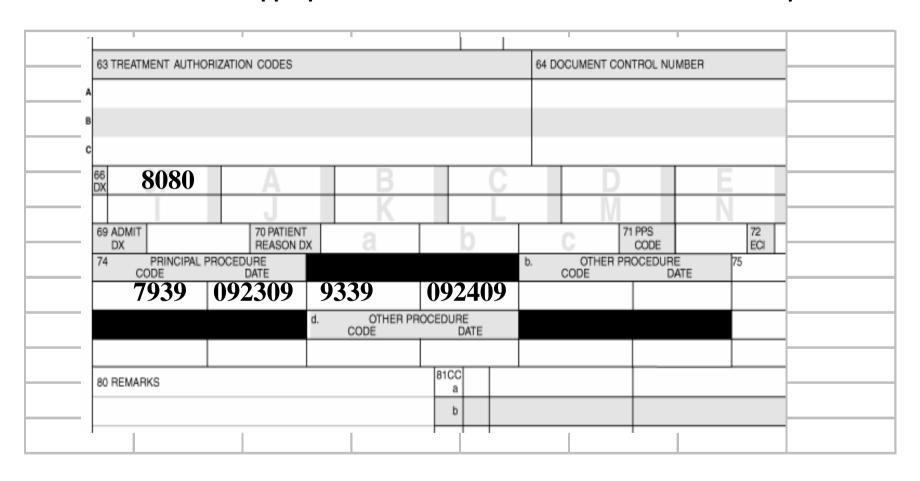
Example # 1: Working through the process

- For this Claim example #1, MS-DRG 460 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount. (The Grouper will also provide the MS-DRG weight of 3.5607 for the current version (26) of the MS-DRG calculation, but usually you will not need to deal with these kinds of details) If you are interested in the mechanics of the calculation, the MS-DRG weight (3.5607) is multiplied by the Montana Base rate (\$7,735) = \$27,542.
- MS-DRG 460 is reimbursed by the Montana Facility Fee Schedule at \$27,542. You can find both the MS-DRG code and its reimbursement amount in "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule" portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor's web page at http://erd.dli.mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V 26.xls

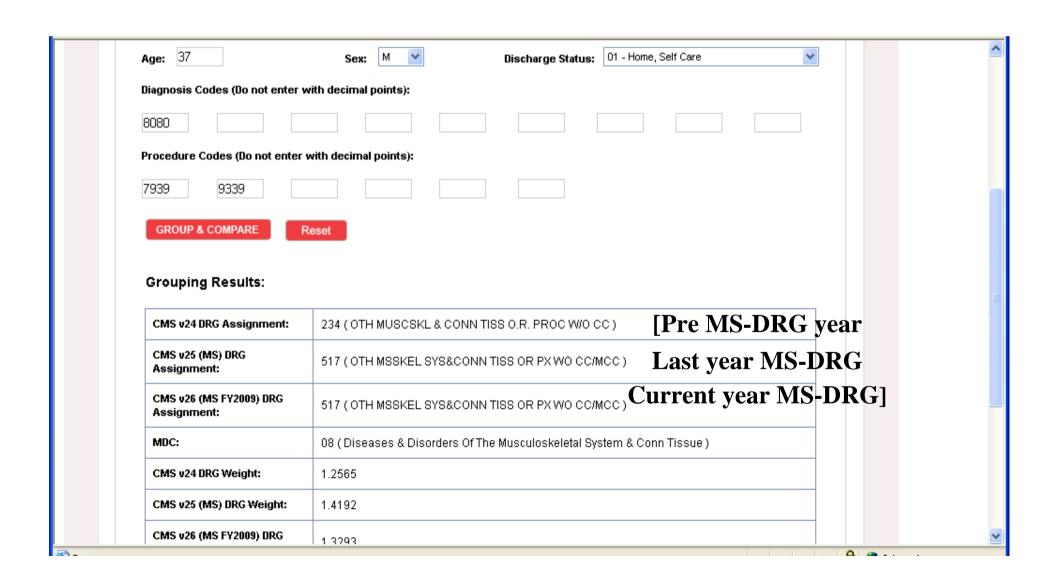
MS-DRG claim example # 2: Example assumes

patient data is already entered into Grouper, and that Block 4 data = 0111.

Now enter the appropriate medical codes listed below into the Grouper.



For example # 2, the MS-DRG is 517, which according to "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule," should be reimbursed at \$10,282



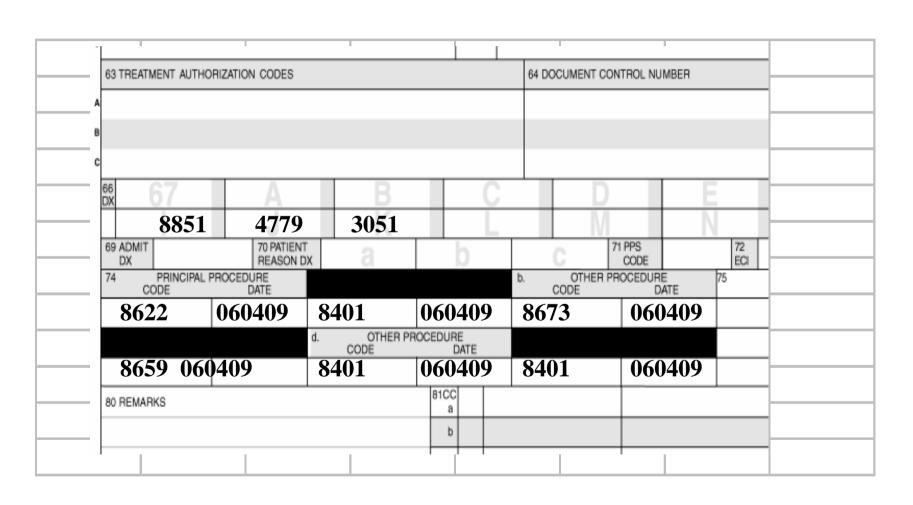
Example # 2: Working through the process

- For this <u>Claim example # 2</u>, MS-DRG 517 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.
- MS-DRG 517 is reimbursed by the Montana Facility Fee Schedule at \$10,282. You can find both the MS-DRG code and its reimbursement amount in "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule" portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor's web page at http://erd.dli.

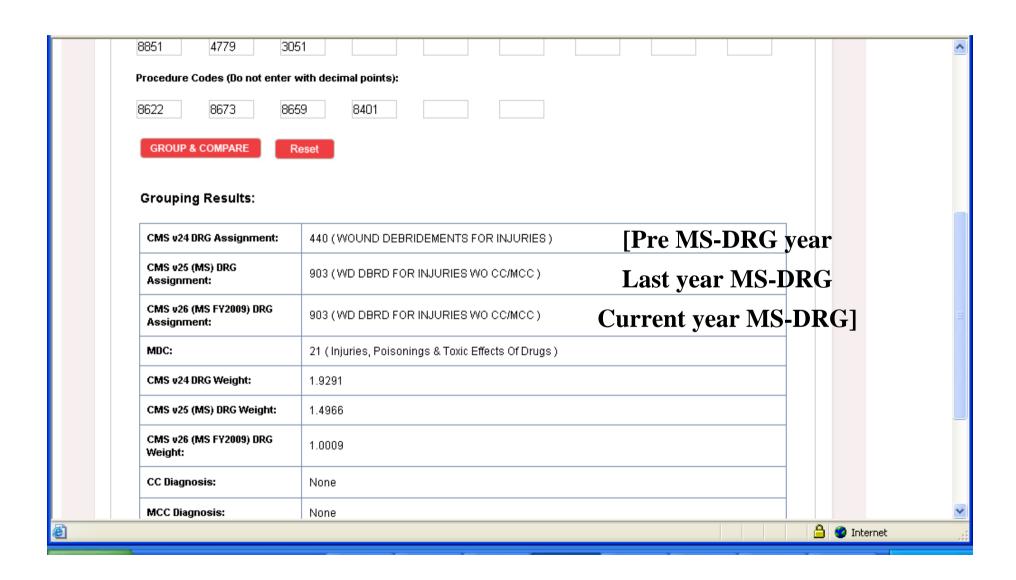
 mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls

MS-DRG claim example # 3: Example assumes

patient data is already entered into Grouper, and that Block 4 data = 0111. Now enter the appropriate medical codes listed below into the Grouper.



Example # 3: in this example, the MS-DRG is 903, which according to "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule," should be reimbursed at \$7,742

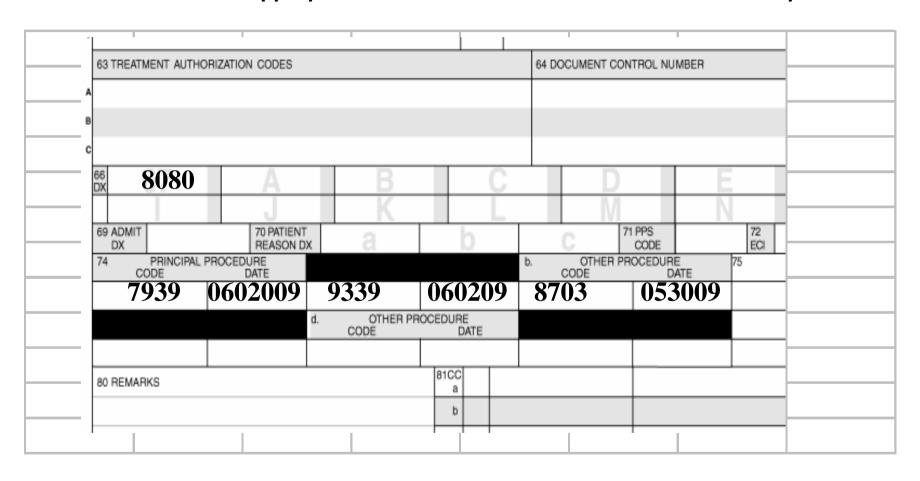


Example # 3: Working through the process

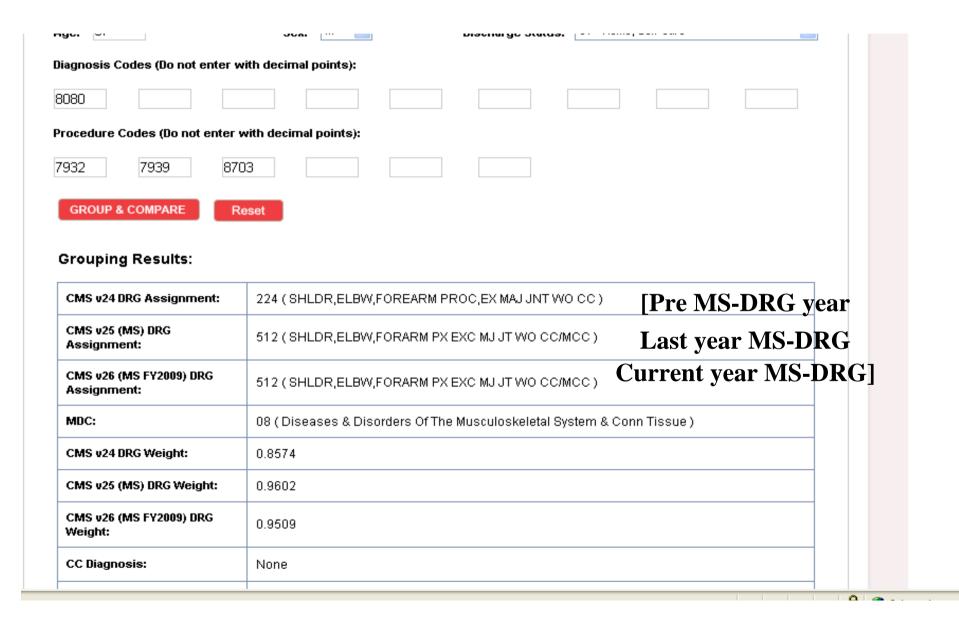
- For this <u>Claim example # 3</u>, MS-DRG 903 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.
- MS-DRG 903 is reimbursed by the Montana Facility Fee Schedule at \$7,742. You can find both the MS-DRG code and its reimbursement amount in "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule" portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor's web page at http://erd.dli.
 - mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls

MS-DRG claim example # 4: Example assumes

patient data is already entered into Grouper, and that Block 4 data = 0111. Now enter the appropriate medical codes listed below into the Grouper.



Example # 4: in this example, the MS-DRG is 512, which according to a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule," should be reimbursed at \$7,355

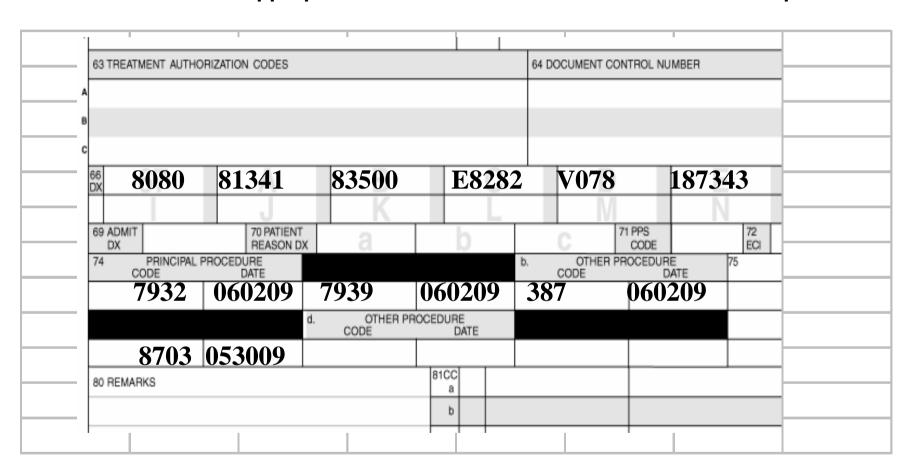


Example # 4: Working through the process

- For this <u>Claim example # 4</u>, MS-DRG 512 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.
- MS-DRG 512 is reimbursed by the Montana Facility Fee Schedule at \$7,355. You can find both the MS-DRG code and its reimbursement amount in "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule" portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor's web page at http://erd.dli. mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls

MS-DRG claim example # 5: Example assumes

patient data is already entered into Grouper, and that Block 4 data = 0111. Now enter the appropriate medical codes listed below into the Grouper.



For example # 5, the MS-DRG is 511, which according to "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule," should be reimbursed at \$10,359.

agnosis Codes (Do not enter w	vith decimal points):
080 81341 835	500 E8490 E8282 V078 187343
ocedure Codes (Do not enter v	with decimal points):
932 7939 387	7 8703
GROUP & COMPARE R	Reset
Frouping Results:	
Prouping Results:	
Grouping Results: CMS v24 DRG Assignment:	224 (SHLDR,ELBW,FOREARM PROC,EX MAJ JNT WO CC) [Pre MS-DRG year
CMS v24 DRG Assignment: CMS v25 (MS) DRG	
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CMS v24 DRG Assignment: CMS v25 (MS) DRG	
CMS v24 DRG Assignment: CMS v25 (MS) DRG Assignment: CMS v26 (MS FY2009) DRG	511 (SHLDR, ELBW, FORARM PX EXC MAJ JT W CC) Last year MS-DRG
CMS v24 DRG Assignment: CMS v25 (MS) DRG Assignment: CMS v26 (MS FY2009) DRG Assignment:	511 (SHLDR, ELBW, FORARM PX EXC MAJ JT W CC) Last year MS-DRG 511 (SHLDR, ELBW, FORARM PX EXC MAJ JT W CC) Current year MS-DRG

Example # 5: Working through the process

- For this <u>Claim example # 5</u>, MS-DRG 511 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.
- MS-DRG 511 is reimbursed by the Montana Facility Fee Schedule at \$10,359. You can find both the MS-DRG code and its reimbursement amount in "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule" portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor's web page at http://erd.dli. mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls
- There is a new element in this bill, namely that the bill charges on the UB-04 total \$41,092, which is more than three times the MS-DRG normal reimbursement amount of \$10,359, so this claim example is likely to be an outlier.

Example # 5 (continued)

Inpatient Outliers

The MS-DRG system is intended to meet the majority of all inpatient reimbursement needs

Occasionally very high medical costs associated with a particular case, known as outlier costs, may require additional reimbursement to the facility

Example # 5 (continued)

Calculating Outlier Payments

- Charges must meet the outlier threshold formula established by the <u>Administrative Rules of Montana (ARM)</u> for inpatient outlier costs
- The threshold formula is the MS-DRG payment multiplied by 3
- [Charges (MS-DRG payment x 3)] x (RCC plus 15%)
- There is a different RCC (Ratio of Cost-to-Charge) for each
 Montana Hospital (for the RCCs, see "(f) The Montana RCC and other
 Montana RCC-based Calculations" section of the Montana Facility Fee
 Schedule)



The Ratio of Costs-to-Charges for Each Hospital are listed on "(f) The Montana RCC and other Montana RCC-based Calculations" section of the Montana Facility Fee Schedule, located on our webpage

(f) The Montana RCC a	ilu otilei ii	iontana	NOO.	บนอะ	u Cai	culati	Ulla		
The table below lists the 14 regulated (acute of	are and long-term	care) hospitals	in Montana	and their	RCCs (Ra	tio of Cost	s to Charg	es) in 2008.	
These RCCs are based on research and analys	sis conducted by the	e Centers for M	edicare and	d Medicaio	1 Services	(CMS).			
utilizing financial reports submitted by each of						, , ,			
terizing interior reports stromitted by each c	in the hospitals.								
When alain mulion on calculated the indivi-	dual hamitalla DCC	Smith a mand a	atha basis	in a alam las					
When claim outliers are calculated, the indivi	duai nospitars RCC	. will be used a	s the basis	in calculat	ions.				
Reimbursement rates in this fee schedule rem			on						
of this fee schedule section referenced in the	Administrative Rul	es of Montana.							
		CMS' 2008							
							_		
		Calculation							
		of Individual							
		Facility							
		Cost to							
Hospital	CMS	Charge							
Name	Provider Number	Ratios	Notes:						
ADVANCED CARE HOSPITAL OF MONTANA								ot yet been given an RC	
BENEFIS HEALTHCARE	270012		or CMS pro	ovider num	per at the tir	ne this data	a table was	developed.	
BOZEMAN DEACONESS HEALTH SERVICES	270057	0.533							
CENTRAL MONTANA MEDICAL CENTER	270011	0.566	01.0	6					
COMMUNITY MEDICAL CENTER BILLINGS CLINIC	270023 270004		(2 2) Sources for the data table include a number of CMS database report sections.						
HEALTHCENTER NORTHWEST	270004		1 particularly "HCRIS 2005 Report of Total Costs, IP Charges and						
HOLY ROSARY HEALTH CENTER	270007		8 Inpatient Charges from Worksheet C, Part I, Line 101, Column 5, 6 6, and 7," et. seg., HCRIS' CostsCharges0907, subset "2005						
KALISPELL REGIONAL MEDICAL CENTER	270051		Hospital C						
NORTHERN MONTANA HOSPITAL	270031		"Hospital20				et. seq., a	T .	
SAINT JAMES COMMUNITY HOSPITAL	270032	0.410		0.0000	2000 61		+	 	
ST. PATRICK HOSPITAL	270014	0.377						 	
ST. PETERS HOSPITAL	270003	0.427	 				 		
SAINT VINCENT HEALTHCARE	270049	0.427	 				 	<u> </u>	

Example # 5 (continued)

Calculating the outlier for Billings Clinic:

- Medical charges total \$41,092,
- And the MS-DRG Payment is \$10,359,
- And the outlier threshold is \$31,077,
- And the RCC (Ratio of Cost-to-Charge) is 0.371,
- Then the outlier payment = (\$41,092-(\$10,359x3)) x
 (0.371 + .15) = \$5,217 to be added to the regular reimbursement
- Therefore total payment is \$10,359 + \$5,217 = \$15,577

Other Considerations

Pay the Bill based on the Fee Schedule

MS-DRG rates are based on a "case mix" formula, so insurers should pay the actual fee schedule reimbursement amount, instead of a higher or lower reimbursement amount the medical provider might bill

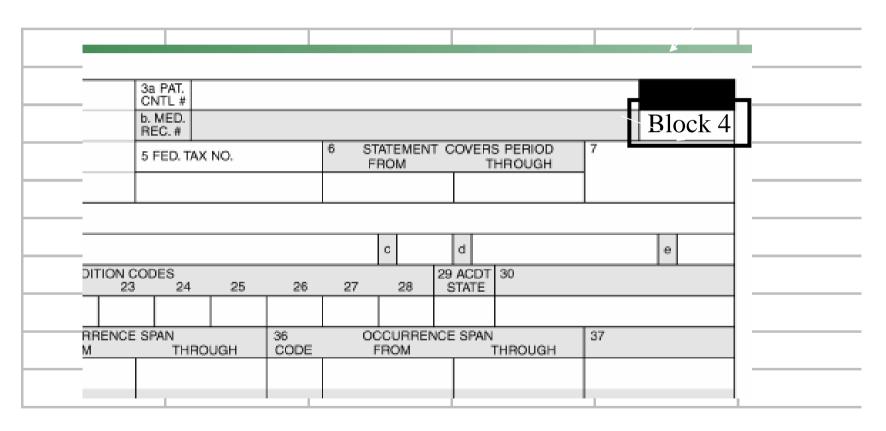
Section Three: Utilizing the UB-04 to Reimburse Outpatient (APC) Bills

Is It An Inpatient or Outpatient Bill?

Remember that a bill from a hospital facility can be for either inpatient or outpatient services, so be sure to confirm that the code entered into **Block 4** on the upper right corner of the UB-04 form is either

- 0111 (inpatient services, for which you use a MS-DRG Grouper as you have just learned above) or
- 0131 (outpatient services, for which you use the APC codes and process, as we
 will now describe in this learning module). Remember also that the APC
 reimbursement system is also used by Ambulatory Surgery Centers (ASCs) for
 billing and reimbursement purposes, so ASC bill information also follows this APC
 billing process
- There are quite a few other facility-related codes that can be entered in Block 4, but most may be payable at one of the 75 percent reimbursement rates described below in Section Four of this learning module

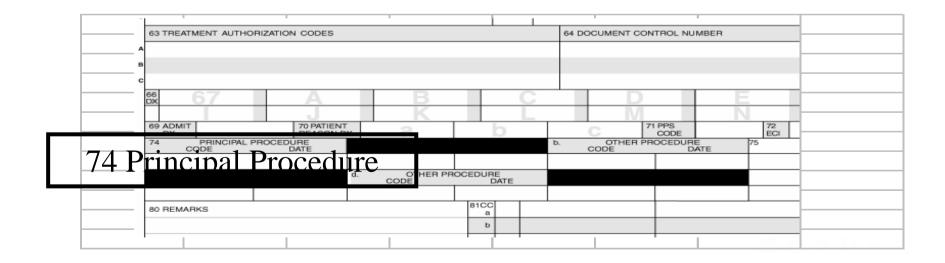
Upper Right Corner of UB-04, Block 4



Does Block 4 include 111, 131, or another code?

The APC Process is more manual: Finding the Matching CPT/APC Codes

- If the UB-04 has code 131 in Block 4, you are all set to process the Outpatient billing
- Step 1: Look up the "Principal Procedure" (PP) code in cell # 74 of the D & P portion of the UB-04, and then compare that PP code to the CPT codes in the "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" section of the Montana Facility Fee Schedule



The APC Process is more manual: Finding the Reimbursement Value of the APC Code

- Step 2: With the APC code identified, use "(b) The Montana Hospital Outpatient and ASC Fee Schedule Organized by APC" of the Montana Facility Fee Schedule to determine the APC reimbursement amount. Remember to select either the "Hospital APC Payment" or "ASC APC Payment" column to properly pay the facility's APC reimbursement.
- Step 3: Return to the non-principal Procedure codes on the UB-04 and identify their respective Status Indicator (SI) codes by looking them up in the "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" section of the Montana Facility Fee Schedule
- Each Status Indicator code will assist you in determining whether the individual non-principal Procedure codes are to be paid separately, are discounted, or are "built into" the APC reimbursement amount already determined for the Principal Procedure code.

The APC Process is more manual: Finding the Reimbursement Value of the Remaining CPT codes via Status Indicator codes

The "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" fee schedule listing includes an entire column (second from left) with Status Indicator (SI) codes

CPT & HCPCS Codes ,	Statu Indica	tor	APC ,	, Relative Weight	Montana Hospital APC Payment	Montana ASC APC Payment				
96900	code	S	0001	0.4806	\$50.46	\$37.97				
96910	S		0001	0.4806	\$50.46	\$37.97				
96912	S		0001	0.4806	\$50.46	\$37.97				
10021	Т		0002	1.1097	\$116.52	\$87.67				
19001	Т		0002	1.1097	\$116.52	\$87.67				
36680	Т		0002	1.1097	\$116.52	\$87.67				
G0364	Т		0002	1.1097	\$116.52	\$87.67				
38220	Т		0003	3.1008	\$325.58	\$244.96				
38221	Т		0003	3.1008	\$325.58	\$244.96				
10022	Т		0004	4.3270	\$454.34	\$341.83				
19000 ,	Т,	7	0004	4.3270	\$454.34	\$341.83				

SI codes let you determine how to reimburse non-principal Procedure codes, and are described for you on "(g) The Montana Status Indicator Codes" section of the Montana Facility Fee Schedule

(a) 1	The Montana Status Indicator (SI) Codes	
(9)	Tie Montana Status Indicator (SI) Codes	
Each APC	, CPT and HCPCS code has been assigned a letter that signifies whether the Montana Facility Fee Scho	edule
	urse the service and how it will be reimbursed. The indicator also helps in determining whether policy re	
	ackaging and discounting, apply. Only Montana Status Indicator codes can be used to calculate	
	ements for services and supplies. Ignore status indicator codes other than A, B, D, F, G, H, K, L, N, P, S,	T and X
	t the fee scheduled amount listed.	
SI Code	SI (Status Indicator) Description .	
A	Fee Schedules:[reimburse] Ambulance[-related codes only].	
В	Non-allowed item or service. Not a hospital service.	
D	Discontinued code.	
F	Acquisition costs paid for Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines.	
G	Additional payment for Drug/Biological pass-through.	
Н	Additional payment for Pass-though device categories, brachytherapy sources, and radiopharmaceutical agents.	
K	[Not a] Pass-through [for] drugs [, devices] and biologicals [These are to be paid separately from the APC].	
L	Flu and other vaccines.	
N	No additional payment, payment included in line items with APCs for incidental service. (Packaged codes not paid separate	rately).
P	Paid Partial hospitalization per diem payment.	
S	Significant procedure not subject to multiple procedure discounting.	
T	Significant procedure, subject to 50% discount on second procedure if present.	
X	Ancillary services.	
1) Please	note the misprint for SI "K" corrected hereon with bracketed text	
2) Please	note the clarification for SI "A" corrected hereon with bracketed text	

Status Indicator codes in Summary:

Montana Status Indicator (SI) codes

- Apply to outpatient services only
- Also help identify how APCs and other codes are reimbursed

Only Montana Status Indicator codes can be used to calculate reimbursements for services and supplies

Ignore status indicator codes other than A, B, D, F, G, H, K, L, N, P, S, T and X, and pay at the fee scheduled amount listed

Please note that:

- SI "A" should only be reimbursed for ambulance-related services, for example stand-by waiting and other services listed on "(d) The Montana Ambulance Fee Schedule" within the Montana Facility Fee Schedule
- SI "K" on the "(g) Status Indicator (SI)" portion of our fee schedule is mislabeled and should instead state "not a pass-through drug or device, and needs to be paid separately from the APC"

Other Useful APC Facts

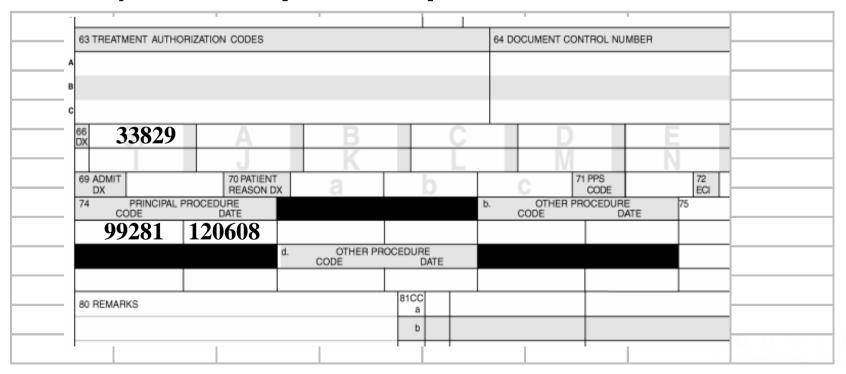
Outpatient services are grouped into APCs

- There may be several APCs per patient per day
- There may be discounts for multiple APCs
- There may be separately payable CPT and HCPCS services
- Montana CCI (Correct Coding Initiative) edits further assist insurers to understand how to reimburse when multiple codes are involved

APC reimbursement levels are different for ASCs and Hospitals

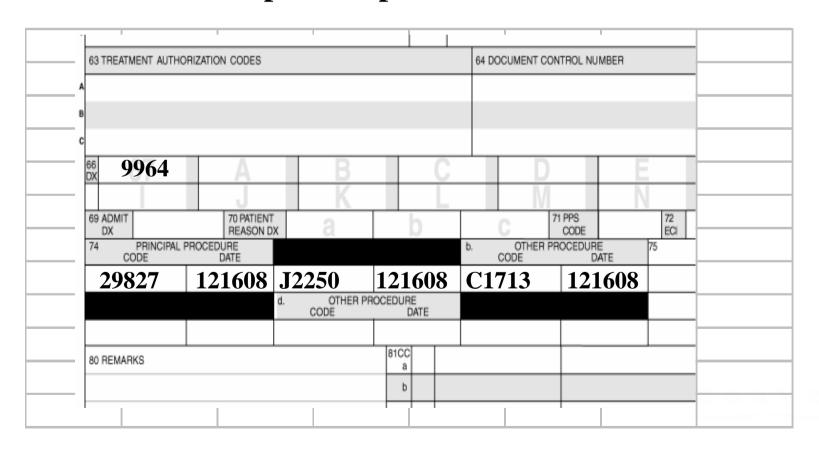
- The basic formula for outpatient reimbursement is the Montana Base Rate times the APC relative weight of a given APC
- For hospitals, the Montana Base Rate is \$105 beginning 12/01/08
- For ASCs, the Montana Base Rate is \$79 beginning 12/01/08
- If no rate is listed and the code is not otherwise included in the <u>Montana Facility Fee Schedule</u> or the <u>Administrative Rules of</u> <u>Montana</u>, the service is to be paid at 75% of the Montana usual & customary charge*
- *In Montana "usual and customary" means the provider's normal charges for a service, and does <u>not</u> include state or regional database information purporting to be usual and customary

APC Example # 1 (with a Block 4 code of 131) is a hospital outpatient service.



- The Principal Procedure code is 99281, which the "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" of the Facility Fee Schedule as APC 609, and which "(b) the Montana Hospital Outpatient and ASC Fee Schedule Organized by APC" reimburses at \$83.69 for hospital outpatient services
- There are no additional CPT/HCPCS codes on the bill, so there are no additional codes to check Status Indicators for additional reimbursements
- The entire reimbursement for this claim is therefore \$83.69

APC Example # 2 (with a Block 4 code of 131) is a hospital outpatient service.



- The Principal Procedure code is 29827, which the "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" of the <u>Facility Fee Schedule</u> lists as APC 42, and which "(b) the Montana Hospital Outpatient and ASC Fee Schedule Organized by APC" reimburses at \$4,799.26 for hospital outpatient services
- There are 2 <u>additional CPT/HCPCS codes</u> on the bill, so there are 2 <u>additional codes to check Status Indicators (SI)</u> in case additional reimbursements should be made for this claim
- HCPCS J2250 has a SI of N, meaning it is bundled into the APC, so there is no separate, additional reimbursement for the first non-principal procedure CPT/HCPCS
- HCPCS C1713 has a SI of N, meaning it is bundled normally into the APC, so there is no separate, additional reimbursement for the second non-principal procedure CPT/HCPCS either. There is separate methodology for direct reimbursement of costs for implants (that also includes reimbursement for shipping, and an additional payment of 15 percent of cost), so this biller is apparently still gathering together the invoices required to document the additional reimbursement, and will submit the invoices at a later time to the insurer.
- The entire reimbursement for this claim at this time is therefore \$4,799.26.

APC Example # 3 (with a Block 4 code of 131) is an

Ambulatory Surgery Center (ASC) outpatient service.

63 TREATMENT AUTHORI	ZATION CODES	64 DOCUMENT	64 DOCUMENT CONTROL NUMBER			
`						
В						
С						
66	Α					
66 DX	A	D				
	J	K			/	N
69 ADMIT	70 PATIENT	2	h	0	71 PPS	72
74 PRINCIPAL PR	REASON DX	a	IJ	b. OTHE	CODE R PROCEDURE	75 ECI
CODE	DATE			CODE	DATE	13
29827	120508	29823	120508	29826	120508	
	d.	OTHER P	ROCEDURE DATE			
		CODE	DATE			
80 REMARKS			81CC			
			b			

- The Principal Procedure code is 29827, which the "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" of the <u>Facility Fee Schedule</u> lists as APC 42, and which "(b) the Montana Hospital Outpatient and ASC Fee Schedule Organized by APC" reimburses at \$3,610.87 for ambulatory surgery center outpatient services
- There are 2 <u>additional CPT/HCPCS codes</u> on the bill, so there are 2 <u>additional codes to check</u>
 Status Indicators (SI) in case additional reimbursements should be made for this claim
- CPT 29823 has a SI of T, meaning it is a significant procedure subject to a 50 percent discount as a second procedure, so there is a separate, additional reimbursement of \$1,805.43 (\$3,610.87 divided by 50 percent)
- CPT 29826 has a SI of T, meaning it is a significant procedure subject to a 50 percent discount as a second procedure, so there is a separate, additional reimbursement of \$1,805.43 (\$3,610.87 divided by 50 percent).
- There is separate methodology for direct reimbursement of costs for implants (that also includes reimbursement for shipping, and an additional payment of 15 percent of cost), so this biller is apparently still gathering together the invoices required to document the additional reimbursement, and will submit the invoices and bill for the implant at a later time to the insurer.
- The entire reimbursement for this claim at this time is therefore \$7,221.74 (\$3,610.87+1,805.43+\$1,805.43).

Other Considerations

Pay the Bill based on the Fee Schedule

APC rates are based on a "case mix" formula, so insurers should pay the actual fee schedule reimbursement amount, instead of a higher or lower reimbursement amount a medical provider might bill

Section Four: Other Ways of Paying

Not every charge on a WC bill goes through either the MS-DRG or APC reimbursement process. Dependent upon the type of facility and/or the nature of the service, procedure or supply, there can be other ways of paying for a WC bill. For example:

- Inpatient rehabilitation services are paid at 75% of the usual and customary charges*
- DME, prosthetics & orthotics (not implantables) are paid at 75% of the usual and customary charges*
- Ambulance services are to be reimbursed based on the "(d) Montana Ambulance
 Fee Schedule" within the Montana Facility Fee Schedule. "Urban areas" in
 Montana are defined as Billings, Great Falls, and Missoula. Only Status Indicator
 (SI) "A" codes for Ambulance-related services are to be reimbursed.

^{*}In Montana "usual and customary" means the provider's normal charges for a service, and does <u>not</u> include state or regional database information purporting to be usual and customary

Section Four: Other Ways of Paying

The following two lists represent the only current Acute Care Hospitals and Ambulatory Surgery Centers Reimbursed by the MS-DRG or APC process

Hospitals

- Advanced Care Hospital of MT, Billings
- Benefis Healthcare, Great Falls
- Bozeman Deaconess, Bozeman
- Central Montana, Lewistown
- Central Montana Surgery Hospital, Gt Falls
- Community Medical Center, Missoula
- Deaconess Medical Center, Billings
- Healthcenter Northwest, Kalispell
- Northern Montana, Havre
- Roundup Memorial, Roundup
- St James Community, Butte
- St. Patrick, Missoula
- St. Peter's Community, Helena
- St. Vincent Hospital, Billings

ASCs

- Big Sky Surgery Center, Missoula
- Billings Cataract & Laser Surgicenter, Billings
- Great Falls Clinic Surgery Center, Great Falls
- Helena Surgicenter, Helena
- Missoula Bone & Joint Surgery Center, Missoula
- Northern Rockies Surgicenter, Billings
- Orthopedic Surgery Center, Kalispell
- Providence Surgery Center, Missoula
- Rocky Mountain Eye Surgery Center, Missoula
- Rocky Mountain Surgical Center, Bozeman
- Same Day Surgery Center, Bozeman
- Summit Surgery Center, Butte
- The Eye Surgicenter, Billings
- Yellowstone Surgery Center, Billings

Section Five: Other Resources

In 2009 CMS published an 8 page electronic fact sheet on the UB-04 form, including a line-by-line explanation of the purpose of all of the form's sections and purposes. It can be found at:

http://www.cms.hhs.gov/MLNProducts/downloads/ub04_fact_sheet.pdf

A much more detailed explanation of the UB-04 form is provided in the CMS publication Medicare Claims

Processing Manual, Chapter 25 - Completing and Processing the Form, CMS-1450 Data Set (126 pages).

Unit Two: Using the UB-04 Understanding Montana Workers' Compensation (WC) Facility Fee Schedule

A Power Point educational module created by the Montana Department of Labor (DLI) in March, 2009. Actual regulations in the Administrative Rules of Montana, of course, take precedence in case of any misstatements in this educational module.

The End